2019 Community Health Needs Assessment
2019-2021 Community Health Improvement Plan
2019 Community Service Plan

Prepared in cooperation with the Healthy Capital District Initiative, Albany and Rensselaer County Health Departments, Burdett Care Center and Albany Medical Center

Submitted in fulfillment of the requirements of the New York State Department of Health Prevention Agenda by St. Peter's Health Partners. Submitted in fulfillment of the requirements of the Internal Revenue Service (pursuant to the Patient Protection and Affordable Care Act of 2010). Adopted by vote of the SPHP Board of Directors on October 31, 2019.

New York State 2019 Community Health
Needs Assessment and Improvement Plan and Community Service Plan

Cover Page

1. Counties Covered:
   Albany and Rensselaer Counties

2. Participating Local Health Department:
   Albany County Health Department
   Rensselaer County Health

3. Participating Hospitals:
   St. Peter's Hospital, Samaritan Hospital, Albany Memorial Hospital, Burdett Care Center, Albany Medical Center Hospital

4. Coalition/entity completing assessment and plan:
   Community Health Needs Assessment – Healthy Capital District Initiative (HCDI), 175 Central Avenue, Albany, New York 12206, 518-486-8400

   Prioritization and Plan – Albany-Rensselaer Prevention Agenda Work Group

Executive Summary

St. Peter's Health Partners (SPHP) has a history of collaborating with community partners to improve the health of Albany & Rensselaer County residents. Local hospital systems including Albany Medical Center and St. Peter's Health Partners (Albany Memorial Hospital, St. Peter's Hospital, Samaritan Hospital and The Burdett Birth Center) and local health departments (Albany & Rensselaer County Health Departments) have cooperated to develop the *SPHP 2019-2021 Community Service Plan*. This unique effort demonstrates inclusive community health improvement planning and assures complementary, non-duplicative efforts to advanced population health.

I. Prevention Agenda Priorities

Working collaboratively through the Healthy Capital District Initiative Albany-Rensselaer Public Health Priority Workgroup (inclusive of local health department, hospitals and community partners) the following priority areas are selected from the Prevention Agenda for the 2019-2021 period:

A. Prevent Chronic Disease: Obesity (and comorbidities)

1) *Reduce obesity and the risk of chronic diseases.*
2) *In the community setting, improve self-management skills for individuals with chronic diseases, including cardiovascular disease, diabetes and prediabetes and obesity.*

B. Prevent Chronic Disease: Asthma

1) *In the community setting, improve self-management skills for individuals with chronic diseases, including asthma.*
2) *Promote tobacco use cessation.*

C. Promote Well-Being and Prevent Mental and Substance Use Disorders

Facilitate supportive environments that promote respect and dignity for people of all ages.

Disparity exists for the incidence of asthma based on geography and race/ethnicity. Accordingly, asthma-related interventions will focus particular attention on communities with the high incidence of asthma in the Cities of Albany & Troy.

II. Emerging Issues and Continuing Projects

The *SPHP 2019-2021 Community Health Improvement Plan* continues to focus on reducing obesity in children and adults and reducing the prevalence of asthma, (priorities previously identified in the *SPHP 2016 - 2018 Community Health Improvement Plan*). The following health needs are not included in the *2019 - 2021 Community Health Improvement Plan*; however, they are being addressed independently by local departments of health and other organizations: adverse birth outcomes, sexually transmitted diseases, non-medical use of prescription pain medication and tick borne diseases.

III. Data Review in the Community Health Needs Assessment

The *SPHP 2019-2021 Community Health Improvement Plan* is based on the collaborative *2019 Capital Region Community Health Needs Assessment* developed by the Healthy Capital District Initiative in collaboration with local health departments, hospitals, community based organizations, businesses, consumers, schools, academics and content area experts and the *SPHP 2019-2021 Community Health Improvement Plan*. Health indicators selected for the *2019 Capital Region Community Health Needs Assessment* were based on a review of available public health data including hospitalizations, emergency room visits, Behavioral Risk Factor Surveillance System, Prevention Quality Indicators and other sources. Siena College Research Institute conducted a Community Health Survey in 2018. Albany and Rensselaer counties conducted Community Health Prioritization Meetings in March 2019. Data and related discussion confirmed a focus on specific health priorities.

IV. Partnerships

Coordinated by the Healthy Capital District Initiative, *2019 Capital Region Community Health Needs Assessment* and *SPHP 2019-2021 Community Health Improvement Plan* involved the active collaboration of local health departments (Albany County Department of Health, Rensselaer County Department of Health); hospital systems (Albany Medical Center, St. Peter's Health Partners) and community partners (e.g. behavioral health providers, community based organizations, schools, worksites, insurance companies). In general, public health will address environmental interventions and hospitals will address health systems interventions. Community Health Improvement Plan implementation will be monitored through existing subject area partnerships (e.g. Albany-Rensselaer Obesity Task Force, Albany-Rensselaer Asthma / Tobacco Coalition, Albany County Strategic Alliance for Health, Albany County Department of Mental Health Providers).

V. Community Engagement

Broad community engagement in the *SPHP 2019-2021 Community Health Improvement Plan* began with public participation in a community health survey. Survey results were incorporated into the examination of health needs by the members of the Albany-Rensselaer Public Health Prioritization Workgroup. The Workgroup included community voices through representatives from consumers, community based organizations that serve low-income residents, the homeless, advocacy groups, employers, public health departments, providers and health insurers.

VI. Planned Interventions and Strategies and Evaluation

All implementation strategies, interventions and process measures are detailed in the *SPHP 2019-2021 Community Health Improvement Plan*. Interventions selected are evidenced-based and most strategies

are provided per the Prevention Agenda 2019-2024 Action Plans (Prevention Agenda Action Plan). In summary:

A. Prevent Chronic Disease: Obesity (and comorbidities)

Objective: By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 2% (Albany County: from 25.0% in 2016 to 24.5% & Rensselaer County: from 30.4% to 28.4% by 2021).

Objective: By December 31, 2021, decrease the decrease the percentage of children with obesity by 2% (Albany County: from 16.0% in 2016-2018 to 15.7% & Rensselaer County: from 16.4% to 14.4% by 2021 among public school students).

Objective: By December 31, 2021, increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 2%; Albany County: from 27.8% (2014-2016) to 28.4% among all WIC infants and Renssealer County: from 19.1% in (2014-2016) to 21.1% among all WIC infants by 2021.

B. Prevent Chronic Disease: Asthma

Objective: By December 31, 2021, decrease the asthma hospitalization rate per 10,000 for all age groups by 2% (Albany County: from 5.2/10,000 in 2016 to 5.1/10,000 & Troy/Lansingburgh (Rensselaer County) from: 22.8/10,000 in 2012-2016 to 22.3/10,000 by 2021).

Objective: By December 31, 2021, decrease the asthma emergency department visit rate per 10,000 for all age groups by 2% (Albany County: from 55.0/10,000 in 2016 to 53.9/10,000 and Troy/Lansingburgh (Rensselaer County) from: 109.8%/10,000 in 2016 to 107.6/10,000 by 2021).

C. Promote Well-Being

Objective: By December 31, 2021 increase Community Score by 2% to 62.2 (baseline: 61.0 in 2018).

By December 31, 2021, reduce the age-adjusted suicide mortality rate by 10% in Rensselaer County from 12.5/100,000 to 11.5/100,000 by 2021.

SPHP will participate in existing community coalitions to specifically track *SPHP 2019-2021 Community Health Improvement Plan* progress and make requisite mid-course corrections.

Mission

"We, St. Peter's Health Partners and Trinity Health, serve together in the spirit of the gospel as a compassionate and transforming healing presence within our communities. Founded in community-based legacies of compassionate healing, we provide the highest quality comprehensive continuum of integrated health care, supportive housing and community services, especially for the needy and vulnerable."

Core Values

Reverence – We honor the sacredness and dignity of every person.

Commitment to Those who are Poor – We stand with and serve those who are poor, especially those most vulnerable.

Justice – We foster right relationships to promote the common good, including sustainability of Earth.

Stewardship – We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity – We are faithful to who we say we are.

SPHP's mission guides everything we do. As we continue our healing ministry into the 21st century, we are called to both serve others and transform care delivery. We reinvest our resources back into the community through new technologies, vital health services and access for everyone regardless of their circumstances.

We call our commitment to the community "Community Health and Well-Being Ministry." Community Health and Well-Being is an organized and measured approach to meeting community health needs. It implies collaboration with a "community" to benefit the "wellbeing" of its residents by improving health status and quality of life.

SPHP's many community health programs are restoring wholeness and well-being to people within the communities we serve.

Year after year, SPHP reinvests in communities with funding for charity care, primary care services, screenings, education and research. And the commitment has risen in proportion to the needs.

Definition and Brief Description of the Community Served

For the purposes of the Community Health Needs Assessment, SPHP defines its primary service area as Albany and Rensselaer Counties which represent the home zip codes of over 70% of its patients.

	Albany	Rensselaer
Population	289,629	172,794
% White	70.5%	83%
% African-American	13.5%	6.7%
% Hispanic	6.6%	5.2%
% High School Graduates	92.2%	90.7%
Median Household Income	$63,329	$65,831

Much more information about the community demographics is contained in the HCDI Community Health Needs Assessment.

Review of the Previous Community Health Needs Assessment (2016)

Key findings of the 2016 CHNA included issues pertaining to Chronic Disease and Behavioral Health. Diabetes and Asthma were the specific health conditions within chronic disease that were selected to be addressed. Asthma in particular was selected due to the significant disparities evident among sub-populations. Prevention of Substance Abuse (e.g. opioid) was selected to be addressed within behavioral health.

Coordinated and led by the Health Capital District Initiative (HCDI), regional task forces were developed: The Regional Behavioral Health Task Force, The Regional Diabetes/Obesity Task Force. Asthma/Tobacco was led by the Asthma Coalition of the Capital District.

Diabetes/ Obesity

Over the past three years, our plan focused on increasing screening rates for pre-diabetes, especially among economically disparate populations; promoting culturally relevant chronic disease management education and creating community environments that promote and support healthy food and beverage choices and physical activity. We worked to expand school and employee wellness programs. Lifestyle change and self-management strategies were promoted to significantly improve quality of life and reduce treatment costs to those with diabetes. These strategies helped to foster an environment that engages individuals in the prevention and self-management of diabetes.

Collectively, the Regional Diabetes/Obesity Task Force executed the following tactics:

- Health care professionals were trained on pre-diabetes screening and resources within the community
- National Diabetes Prevention Programs (NDPP) participation increased in Albany and Rensselaer Counties
- Creating Health Schools and Communities Grant provided technical assistance in developing implementation strategies for health and wellness policies within Albany and Rensselaer County school districts
- 2,000 revised Diabetes Resource guides were printed and distributed to providers and consumers (also available electronically)
- Employer sponsored wellness program continued to increase access to healthy lifestyle and physical activity
- 1,500 children within Albany and Rensselaer counties participated in Soccer for Success, an evidence-based after school program focused on physical activity and healthy lifestyle. 88% of participants either maintained or decreased their individual BMI level

St. Peter's Health Partners (St. Peter's Hospital, Albany Memorial Hospital, Burdett Care Center and Samaritan Hospital) Related Initiatives:

- Facilitated a total of 12 National Diabetes Prevention Program (NDPP) groups
- 194 participants completed a NDPP program, having an average weight loss of 4.4% per group and an average of 200 activity minutes recorded
- As a result of our Healthy Vending policy, 60% of the snack and beverage selections are from healthier stocking standards
- Provided employee wellness and physical activity programs to our 12,000 colleagues. Five to six wellness and physical activity programs were offered yearly
- Provided technical assistance to 6 school districts within Albany and Rensselaer counties to implement strong school wellness policies

As a result of these initiatives both collectively and internally, obesity rates decreased in Albany County. Adult: from 26% to 25.3%. Children: 17% to 16%.

Asthma/Tobacco Cessation:

During the past three years, members of the Asthma Coalition of the Capital District worked to reduce the prevalence of uncontrolled asthma in high prevalence neighborhoods. The focus was on increasing the number of patients engaged in an asthma continuum of care and increasing the utilization of asthma action plans and controller medication. Strategies promoted community environments in enacting tobacco-free policies and engaging the community in tobacco cessation programs.

Collectively:

- Our work with the community agencies resulted in numerous communities implementing tobacco free parks and public housing units becoming tobacco free; passage of tobacco control legislation, such as local and statewide Tobacco 21 and Tobacco Free Pharmacies in Albany County
- Over 3,500 healthy neighborhood and certified asthma educator visits were conducted in order to expand asthma home based self-management programs
- Over 3,330 individuals within Albany and Rensselaer counties were referred to the NYS Smoker's Quitline for tobacco cessation assistance

St. Peter's Health Partners (St. Peter's Hospital, Albany Memorial Hospital, Burdett Care Center and Samaritan Hospital) Related Initiatives:

- The SPHP Home Based Asthma program, which arranged for patient visits in their homes by a Respiratory Therapist, Registered Nurse and Community Health Worker, provided appropriate asthma education to 1,030 patients
- SPHP Health Care Providers were educated on the availability of the home based asthma program and tobacco cessation resources, in order to decrease the number of adults who use tobacco products
- 50+ individuals have been trained as asthma educators through our Certified Asthma Educator Program. Our work with community agencies resulted in several legislative changes such as tobacco free pharmacies in Albany County, local and statewide Tobacco 21, which prohibits the sale of tobacco products (inclusive of electronic cigarettes and vaping devices) to persons under the age of 21
- 126 participants enrolled in *The Butt Stops* Here tobacco cessation program offered at St. Peter's Health Partners locations
- An electronic referral system was created enabling patients of SPHP to be referred to be the NYS Smokers Quitline by SPHP physician practices, through direct connectivity for referrals from the electronic medical record
- 3,064 individuals from our hospitals and ambulatory sites were referred to the NYS Smokers Quitline for tobacco cessation assistance

As a result of these initiatives both collectively and internally, the age adjusted asthma hospitalization rate per 10,000 decreased from 11.2% to 5.7% in Albany County and from 10.5% to 6.1% in Rensselaer County. Also, the percentage of adults who smoke decreased from 24.8% to 18.3% in Rensselaer County.

Substance Abuse (particularly opioid abuse):

In order to increase education and practice strategies to reduce opioid overdose and non-medical use of opiates, our plan, over the last three years, included provider education of addiction and pain management (prescribing guidelines and community resources for prevention, addiction treatment and recovery support), information to provide to patients regarding risk of harm and misuse, promotion of safe storage and proper disposal of unused prescription medications (community education, increase disposal opportunities), New York State Opioid Overdose Prevention Training and establishment of ambulatory detoxification service locations.

Collectively, members of the Regional Behavioral Health Task Force:

- Trained over 2,500 individuals Naloxone/Narcan Training to prevent heroin overdosing and sudden death within Albany and Rensselaer counties
- Both Albany and Rensselaer counties participated in task force meetings, which provided a forum for coordinating activities of public health, public safety and behavioral health resources, with regards to the non-medical use of opioids and prescription pain medication
- Established ambulatory opioid withdrawal programs and increased the number of "x waivered" licensed health care providers
- Dozens of locations participated in regularly scheduled drug "take back " days to remove opioids from consumer's homes
- Health Care Providers were educated regarding prescribing consistent with updated state and federal guidelines

St. Peter's Health Partners (St. Peter's Hospital, Samaritan Hospital Burdett Care Center and Albany Memorial Hospital) Related Initiatives:

- Established four ambulatory opioid withdrawal programs, which provided services to nearly 1,000 patients. An additional 13 providers became "x" licensed, meaning the provider is waivered to prescribe and dispense buprenorphine in office-based treatment of opioid disorders
- 630 of our providers were educated on addiction and pain management, consistent with updated state and federal guidelines.

Written Comments on Prior CHNA

The CHNA is well-known in our community, and local health departments as well as numerous community based agencies have been involved throughout the process of selecting priorities and developing improvement plans. No specific written comments have been received.

Community Health Needs Assessment 2019

SPHP collaborated with other local health systems, county health departments and community based agencies to complete a six county (Albany, Rensselaer, Schenectady, Saratoga, Columbia and Greene) Community Health Needs Assessment, led by the Healthy Capital District Initiative (HCDI). HCDI is an incorporated not for-profit which works with others in the community to determine ways in which the Capital Region could be more effective in identifying and addressing public health problems.

For the purposes of its CHNA, SPHP used data and information from this assessment relating to Albany and Rensselaer Counties, which represent the home zip codes of over 70% of its patients. Other health systems will be addressing the needs of remaining counties in the assessment based on their location and patient population.

The 2019 Capital Region Community Health Needs Assessment, prepared by the Healthy Capital District Initiative (HCDI) of which St. Peter's Health Partners is a member, provides more detailed information and data regarding health issues of concern in Albany & Rensselaer Counties: *2019 Capital Region Community Health Needs Assessment*

Data Sources and Indicator Selection

The health indicators selected for this report were based on a review of available public health data and New York State priorities promulgated through the *Prevention Agenda for a Healthier New York*. Upon examination of these key resources, identification of additional indicators of importance with data available and discussion with public health, as well as health care professionals in the Capital Region, it was decided that building upon the recent 2013-2018, and new 2019-2024 Prevention Agenda would provide the most comprehensive analysis of available public health needs and behaviors for the Region. The collection and management of these data has been supported by the state for an extended period and are very likely to continue to be supported. This provides reliable and comparable data over time and across the state. While the 2019-2024 Prevention Agenda objectives and indicators have been developed, the present Prevention Agenda Dashboard still contains 2013-2018 indicators with corresponding data (as of May 2019). These measures, when complemented by the recent Expanded Behavioral Risk Factor Surveillance System and Prevention Quality Indicators, provide health indicators that can be potentially impacted in the short-term.

The Common Ground Health provided SPARCS (hospitalizations and ED visits) and Vital Statistics Data Portals that were utilized to generate county and ZIP code level analyses of mortality, hospitalizations and emergency room utilization, for all residents, by gender, race and ethnicity. The time frames used for the zip code analyses were 2010-2015 Vital Statistics and 2012-2016 Statewide Planning and Research Cooperative System (SPARCS) data. The 5-year period establishes more reliable rates when looking at small geographic areas or minority populations.

Additional data was examined from a wide variety of sources:

- Prevention Agenda 2013-18 Dashboard of Tracking Indicators (2016)
- Community Health Indicator Reports Dashboard (2014-2016)
- County Health Indicators by Race/Ethnicity (2014-2016)
- County Perinatal Profiles (2012-2014, 2014-2016)
- Vital Statistics Annual Reports (2014, 2015, 2016)
- Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS (2016)
- Cancer Registry, New York State (2011-2015)
- Prevention Quality Indicators (2014-2016)
- Communicable Disease Annual Reports (2013-2017)
- The Pediatric Nutrition Surveillance System (PedNSS) (2014-2016)
- Student Weight Status Category Reporting System (2014-2016)
- County Opioid Quarterly Reports (April 2017-October 2018)
- NYS Opioid Data Dashboard (2016-2017)
- NYS Child Health Lead Poisoning Prevention Program (2013 birth cohort, 2014-2016)
- NYS Kids' Well-being Indicator Clearinghouse (KWIC) (2012-2014, 2017)
- County Health Rankings (2019)
- American Fact Finder (factfinder2.census.gov) (2017)
- Bureau of Census, American Community Survey (2012-2016)

These data sources were supplemented by a Siena College Research Institute Community Health Survey. The 2018 Community Health Survey was conducted in December 2018 by the Siena College Research Institute. The survey was a representative sample of adult (18+ years) residents of the Capital Region. The survey included 1,204 (MOE +/- 3.4%) total interviews made up of a phone sample, oversample of low income residents and a small online sample. This consumer survey was conducted to learn about the health needs, barriers and concerns of residents in the Capital Region. The Appendix (2018 Capital Region Community Health Survey) contains a detailed summary of the findings, as well as the questionnaire used.

Collaboration and Community Engagement

Engaging the community in the health needs assessment process was a priority of St. Peter's Health Partners and other stakeholders. Broad community engagement began with participation in the community health survey.

The survey offered multiple choice and open-ended questions to learn about residents' health needs and priorities, health behaviors, barriers to care and social determinants of health. Demographic information collected by the survey allowed review of information by age, gender, race/ethnicity and income.

Survey results regarding the public's experience with opioid abuse and opinions on the seriousness of public health issues were incorporated into the examination of health needs by the members of the four Capital Region Prevention Agenda Prioritization Work Groups (Albany, Rensselaer, Columbia-Greene, Saratoga and Schenectady). The Work Groups included community voices through representatives from community based organizations that serve low-income residents, the homeless and other vulnerable populations; federally qualified health centers; advocacy groups; employers; public health departments; providers and health insurers. Participants were encouraged to share data of their own and to advocate for the needs of their constituents. HCDI and its stakeholders strategically invited partners with unique access to the medically underserved population.

Selection of Priorities

Selection of the top health priorities for the Capital Region was facilitated by a new Public Health Issue Prioritization tool created by HCDI based on feedback from the 2016-2018 Prioritization Cycle. In the fall of 2018, HCDI staff reviewed approximately 170 Public Health Indicators across the five Prevention Agenda priority areas and incorporated the key indicators into 30 Public Health Issues. Public Health Issues were identified by reviewing the present Prevention Agenda Focus Areas, as well as Public Health Issues incorporated in the last Prioritization Process in 2016, and were ranked for each of the six counties in the Capital Region. The ranking tool utilized a quantitative method, based on previous prioritization efforts (e.g. Hanlon Method), to assist the county selection process from 30 Public Health Issues to a shorter list of health issues for participating partners to examine and make their final selections. Each indicator variable was scored on five dimensions:

- Size relative to Upstate;
- Impact on quality of life;
- Trend from 2013-2015 or a comparable timeframe;
- Disparity (Index of Disparity using race/ethnicity); and
- Absolute number of individuals affected.

A comprehensive overview of the ranking methodology can be found on the HCDI website (http://hcdiny.org) by selecting "Explore by County" and locating "Public Health Issue Prioritization Methodology Review" in the "County Data and Resources" section.

A Prevention Agenda Work Group Steering Committee, with participation from local health departments of Albany, Columbia, Greene, Rensselaer, Saratoga and Schenectady counties, St. Peter's Health Partners, Ellis Medicine, Albany Medical Center, Saratoga Hospital and Columbia Memorial Hospital, met in winter 2018 to review the Ranking Methodology and provide oversight and guidance in the prioritization process. Using the quantitative rankings provided by the tool as well as consideration of the availability of quality data, adequacy of current efforts, organizational capacity, upstream vs. downstream factors, and potential for evidence based interventions, Steering Committee participants selected 12-15 Public Health Issues for more comprehensive review by the Prevention Agenda Prioritization Work Groups.

The local Prevention Agenda Prioritization Work Groups were formed to review data analyses prepared by HCDI for the Public Health Issues identified by the Prevention Agenda Work Group Steering Committee and to select at least two priorities with one health disparity to be addressed. Available data on prevalence, emergency department

visits, hospitalizations, mortality and trends were included for each indicator. Equity data for gender, age, race/ethnicity and neighborhood groupings were presented as available. Prior to the presentation, the full data set reviewed by the Prevention Agenda Work Group Steering Committee was made available to Capital Region partners on the HCDI website (http://hcdiny.org/). Presentations can be found by selecting "Explore by County" and opening the "2019 Prevention Agenda Prioritization Presentation" under the "County Data and Resources" section.

After the presentation of each set of health indicators, a discussion was held to answer any questions, or allow individuals to share their experiences with the health condition in the population. Participants were encouraged to consider the importance of the condition in the community based on three qualitative dimensions: what the data and organizational experiences suggested; if there was community awareness and concern about the condition; and the opportunity to prevent or reduce the burden of this health issue on the community. Participants were provided with a Prioritization Tracking Tool to record their own comments and measure their thoughts on the local experience, community value and potential opportunity regarding each health indicator.

Upon completion of the data summaries, Prevention Agenda Prioritization Work Groups members were given an opportunity to advocate for the priority they believed was most meritorious and the group voted on the top two Prevention Agenda categories. Behavioral health and chronic disease categories received the greatest amount of votes by far, because they impacted the largest number of people in the most significant ways, both directly and indirectly, through their influence on other health conditions. They also contributed most significantly to the cost of health care.

Albany-Rensselaer Prevention Agenda Prioritization Workgroup

The Albany-Rensselaer Prevention Agenda Prioritization Workgroup was spearheaded by the Albany County Department of Health, the Rensselaer County Department of Health, Albany Medical Center and St. Peter's Health Partners. Because the hospitals' catchment areas covers both counties, a joint county workgroup felt appropriate. Two meetings were held on March 1 and March 21, 2019. During these meetings, HCDI presented data for the 9 selected heath indicators and facilitated Albany-Rensselaer Prevention Agenda Prioritization Workgroup discussions. The Power Point data presentations used during these meetings were made available to the Albany-Rensselaer Prevention Agenda Prioritization Workgroup members and the public on the HCDI Website (http://www.hcdiny.org/).

The Albany-Rensselaer Prevention Agenda Prioritization Workgroup chose their priorities at the second workgroup meeting. Organizations participating in the Albany-Rensselaer Prevention Agenda Prioritization Workgroup:

- Albany County Department for Aging
- Albany County Department of Health
- Albany County Department of Mental Health
- Albany Medical Center
- Albany Medical Center: DSRIP (Better Health for Northeast New York, Inc.)
- Alliance for Better Health
- Alliance for Positive Health
- AVillage, Inc.
- Blue Shield of Northeastern New York, Inc.
- Burdett Birth Center
- Capital District Boys and Girls Club
- Capital District Physicians' Health Plan (CDPHP)
- Capital District Tobacco-Free Coalition
- Capital Roots
- Catholic Charities of the Diocese of Albany

- Cornell Cooperative Extension
- Healthy Capital District Initiative
- Hudson Valley Community College
- Independent Living Center of the Hudson Valley
- MVP Health Care, Inc.
- Promesa/Camino Nuevo
- Rensselaer County Department of Health
- Rensselaer County Department of Mental Health
- St. Peter's Health Partners
- The Baby Institute
- The Food Pantries for the Capital District
- United Way of the Greater Capital Region
- Upper Hudson Planned Parenthood
- Whitney Young Health Center

Almost all of these organizations serve medically underserved, low income or minority populations; many offer specific programs targeted towards these groups.

The significant health needs identified, in order of priority include:

1) Obesity/Diabetes	– In Albany County, approximately 57,000 adults (25.3%) and 7,200 children and adolescents (16%) were considered obese. In Rensselaer County the adult obesity rate of 31.5% (36,000) and child and adolescent obesity rate of 18.7% (4,500) were both higher in comparison to NYS excluding NYC, commonly referred to as Rest of State (ROS) – Albany and Rensselaer County's rates for diabetes short-term complication hospitalization were both higher than ROS. Albany County's adult diabetes prevalence rate of 9.0% was higher than ROS (8.5%)
2) Asthma/Tobacco Use	– Asthma prevalence and asthma emergency department visit rate were higher than ROS in Albany and Rensselaer counties. – In Rensselaer County, the adult smoking rate of 18.3% was higher than ROS. In addition, according to the NYS Department of Health, the cigarette smoking prevalence in youth has increased for the first time since 2,000, from 2.3 in 2016 to 4.8% in 2018. At the same time, there has been an alarming trend in electronic cigarette use among high school students in NYS. The use of e-cigarettes has increased from 10.5% in 2014 to 27.4% in 2018 (a 160% increase)
3) Mental Health	– Both Albany and Rensselaer Counties had a higher mental disease and disorder ED visit than ROS – Males had 1.1-1.6 times higher mental disease/disorder ED visit and hospitalization rates compared to females

4) Substance Use	– Both Albany and Rensselaer Counties had a higher drug abuse ED visit and hospitalization rate compared to ROS and fell into the 3rd or 4th risk quartile – Since 2010, Albany County's opiate overdose mortality rate has increased 170%, while Rensselaer's rate increased 80%
5) Sexually Transmitted Infections	– Albany County fell to the 4th risk quartile for all STD indicators and Rensselaer fell the 4th risk quartile for gonorrhea and syphilis indicators and the 3rd risk quartile for chlamydia – In the past five years, Albany County's gonorrhea case rate increased 96% and chlamydia case rate increased 30%, while in Rensselaer County, the gonorrhea case rate increased 175% and chlamydia case rate increased 24%
6) Lyme Disease	– Rensselaer County's Lyme disease case rate of 395.5/100,000 was higher than ROS and the 3rd highest rate of all NYS counties. Albany County's Lyme disease case rate of 148.6/100,000 was also higher than the ROS
7) Maternal/Infant Health	– Both Albany and Rensselaer County had higher teen (15-17years) pregnancy rate than the ROS – Albany County had a lower rate of early prenatal care than the ROS and the late or no prenatal care was higher than the ROS. Rensselaer County's rate of premature births (<37 weeks gest.) of 9.7% was higher than ROS

Significant health needs to be addressed

Following review of the significant health needs of the community, the Albany-Rensselaer Workgroup determined they will focus on developing and/or supporting initiatives and measure their effective ness, to improve the following health needs:

I. PRIORITY AREA: PREVENT CHRONIC DISEASE
   - Reduce Obesity and Prevent Diabetes
   - Prevent/Control Asthma and Prevent Tobacco Use

II. PRIOIRTY AREA: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS
   - Promote Well-being

Existing task forces will have their scope modified or new task forces will be established to develop and implement Community Health Improvement Plans for each of the priority areas selected. For example, the existing Obesity-Diabetes Task Force will review and revise their efforts to prevent obesity and type 2 diabetes, and help patients learn how to self-manage and live a healthy lifestyle. The Asthma/Tobacco Prevention Task Force will work with existing coalitions like Capital District Tobacco-Free Communities, who currently collaborates with the Albany County Strategic Alliance for Health, as well as the Asthma Coalition of the Capital Region. Addressing mental health will require collaboration with both Albany and Rensselaer counties' Departments of Mental Health. Mental health may also call upon DSRIP (Delivery System Reimbursement Incentive Payment Program) activities as well as the regional health home, Capital Region Health Connections.

Significant health needs that will not be addressed

St. Peter's Hospital acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. St. Peter's Hospital will not take action on the following health needs:

- **Substance Use –** St. Peter's Hospital does not plan to directly address this particular need through the CHNA implementation strategies, because the county health departments and county departments of mental health are taking the lead on this issue. SPHP will support their activities, by offering inpatient and outpatient substance use treatment programs
- **Sexually Transmitted Infections –** St. Peter's Hospital does not plan to directly address this particular need because the county health departments are taking the lead on this issue. SPHP will support their activities
- **Lyme Disease –** St. Peter's Hospital does not plan to directly address this particular need because the county health departments are taking the lead on this issue. SPHP will support their activities
- **Maternal Infant Health –** St. Peter's Hospital does not plan to directly address this particular need because the county health departments are taking the lead on this issue. SPHP will support their activities.

This implementation strategy specifies community health needs that the hospital has determined to address in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.

Governing Board Review

The St. Peter's Health Partners Board of Directors approved this Community Health Needs Assessment on 6/28/19 and the Community Health Improvement Plan on 10/31/19.

Communication

This Community Health Needs Assessment and subsequent Community Health Improvement Plan were made available to the many community members and organizations who participated in the process. In addition, we work closely with the health community collaborative in both Albany and Rensselaer Counties (Albany County Strategic Alliance for Health and the Rensselaer County Wellness Committee). The documents are posted on the St. Peter's Health Partners website (www.sphp.com/community-health), The Burdett Birth Center Website (www.burdettbirthcenter.org/resources/community-health) and on each of the hospital's websites. Paper copes may be requested by contacting:

St. Peter's Health Partners
Community Health & Well-Being Office
315 South Manning Boulevard
Albany, NY 12208
518-525-6640

Comments about this document may also be sent to the address above; Subject: CHNA Comments

COMMUNITY HEALTH IMPROVEMENT PLAN

Prevent Chronic Disease(s): Obesity Albany & Rensselaer Counties

Goal 1: Reduce obesity and the risk of chronic diseases

Target Population: Adults and Children

Objective(s): By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 2% (Albany County: from 25.0% in 2016 to 24.5% & Rensselaer County: from 30.4% to 28.4% by 2021).

By December 31, 2021, decrease the decrease the percentage of children with obesity by 2% (Albany County: from 16.0% in 2016-2018 to 15.7% & Rensselaer County: from 16.4% to 14.4% by 2021 among public school students).

By December 31, 2021, increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 2% (Albany County: from 27.8% (2014-2016) to 28.4% among all WIC infants and Renssealer County: from 19.1% in (2014-2016) to 21.1% among all WIC infants by 2021)

Address Disparity: No

Intervention/ Strategies, Activities	Partner Resources	Partner Roles	Measures
Improve health behaviors and results through worksite nutrition and physical activity programs.	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Rensselaer County Department of Health** • Implement a combination of worksite-based physical activity polices, programs and best practices through physical activity and nutrition programs. **Albany Medical Center** • Implement a combination of worksite-based physical activity polices, programs and best practices through physical activity and nutrition programs. **St. Peter's Health Partners**	**Albany County Department of Health:** Provides technical assistance to worksite environments that implement nutrition / beverage standards and/or increase physical activity. **Rensselaer County Department of Health** • Create and implement a new worksite Wellness program for it's employees **Albany Medical Center** • Promote healthy living and wellness through Albany Med's 4-pronged wellness program including healthy nutrition, education, and physical activity and employee education activities. **St. Peter's Health Partners**	• Number of worksites that improve nutrition, physical activity policies and practices (including number of persons impacted by standards and improvements in worksite wellness). • To the extent possible, pre- and post-implementation of *CDC Worksite Health Scorecard* (or comparable resource) demonstrated for at

	• Adopted a health and wellness policy that impacts patients and employees **Healthy Capital District Initiative (HCDI):** Provides access to coverage and care, health-planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	• Promote and encourage healthy living through the St. Peter's Health Partners Wellness Committee • Actively participates in the Albany-Rensselaer Diabetes and Obesity Taskforce **American Heart Association, Capital District YMCA:** provide technical assistance to worksites. **HCDI Obesity Task Force:** Promote & provide support to outreach activities in Albany and Rensselaer counties.	least one (1) worksite.
Increase support for breastfeeding in the workplace.	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Albany Medical Center:** • Increase access to lactation support by the following: professional support, peer support and formal education **BrightSideUp:** Provides resources to the community in order to improve the availability and quality of child care. **St. Peter's Health Partners:** • St. Peter's Hospital awarded Baby Friendly designation by *Baby Friendly USA* • Increase access to peer and professional breastfeeding support within the community • Created worksite lactation policies	**Albany County Department of Health:** Coordinate breastfeeding partnership; increase number of worksites that provide breastfeeding accommodations. **Albany Medical Center:** Women, Infants, and Children (WIC) Program provides access to healthy foods for growth and development and promotes food nutrition through education. **BrightSideUp:** Promotes breastfeeding friendly child care centers **St. Peter's Health Partners:** • Provides access to peer and professional breastfeeding support in the hospital and community Baby Cafes (drop-in centers) • Maintain lactation rooms in each hospital facility, in accordance with worksite lactation policy.	• Number and percentage of engaged worksites that improve their policies to support breastfeeding. • Number and percentage of engaged worksites that improve their practices to support breastfeeding.

		• Actively participates in the Albany-Rensselaer Diabetes and Obesity Taskforce	
	Whitney M. Young Jr. Health Services: federally qualified health center.	**Whitney M. Young Jr. Health Services:** Women, Infants, and Children (WIC) Program provides access to healthy foods for growth and development and promotes food nutrition through education.	
	Healthy Capital District Initiative (HCDI): Provides access to coverage and care, health-planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	**HCDI Obesity Task Force:** Promote & provide support to outreach activities in Albany and Rensselaer counties.	
Increase food security	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Rensselaer County Department of Health** • Develop a tracking method for food insecurity screening and referrals **St. Peter's Health Partners:** • Develop a process to screen patients of SPHP for food insecurity and provide appropriate referrals, as necessary, via a closed loop process**.**	**Albany County Department of Health:** Implement *Healthy Habits Program* (including facilitating screening and referral for food security; support enrolled families with self-management of disease and healthy food access). **Rensselaer County Department of Health** • Develop a resource guide for Rensselaer County Department of Mental Health providers to give to patients who are experiencing food insecurity**.** **Boys & Girls Clubs of the Capital Area:** Provide *Nutrition and Food Security Interventions for Children, Youth and Families*. **St. Peter's Health Partners:** • Implement food insecurity screening, facilitate and actively support closed loop food assistance referrals within SPHP acute and ambulatory settings. • Actively participates in the Albany-Rensselaer Diabetes and Obesity Taskforce	• Number of adults and children participating in *Healthy Habits Program.* • Number and percentage of *Healthy Habits Program* participants screened for food insecurity. • Number and percentage of *Healthy Habits Program* participants identified as food insecure. • To the extent possible, Pre- and post- intervention measurement of food insecure

	Healthy Capital District Initiative (HCDI): Provides access to coverage and care, health-planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	**HCDI Obesity Task Force:** Promote and provide support to outreach activities in Albany and Rensselaer counties.	*Healthy Habits Program* participants for referrals to resources.
Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Rensselaer County Department of Health** • Provide assistance in developing and implementing strategies for health and wellness policies within school districts in Renssealer County **Albany Medical Center:** • Implement a combination of worksite-based physical activity policies, programs, or best practices through physical activity and/or nutrition programs. **St. Peter's Health Partners:** • Awarded the Creating Healthy Schools and Communities grant from NYS Department of Health that seeks to increase opportunities for physical activity and improve nutritious foods in both the community and school districts. • Provides funding to evidence based physical activity and healthy lifestyle programs within the community.	**Albany County Department of Health:** Provide technical assistance in promoting physical activity in community venues. • Implement new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes)with new or improved land use or environmental design components **Rensselaer County Department of Health** • Public health educator leads a local school district's wellness committee. Committee provides assistance in developing and implementing strategies for health and wellness policies within the school district. **Albany Medical Center:** • Promote healthy living and wellness through Albany Med's 4-pronged wellness program including healthy nutrition education, physical and emotional wellness, and employee education activities. **St. Peter's Health Partners:** • Provides technical assistance in developing implementation strategies for health and wellness policies within school districts in Albany and Renssealer Counties • Provides support to the Boys and Girls Club, Soccer for Success Program; an evidence based physical activity and	• Number of places that implement new, or improve existing, community planning and transportation interventions that support safe and accessible physical activity. • • Number of Schools that implement strong school wellness and physical activity policies

	HCDI: Provides access to coverage and care, health-planning expertise and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	healthy lifestyle program for children age 5-14 **HCDI Obesity Task Force:** Promote & provide support to outreach activities throughout both counties.	

Prevent Chronic Disease(s): Obesity Albany & Rensselaer Counties

Goal 2: In the community setting, improve self-management skills for individuals with chronic diseases, including cardiovascular disease, diabetes and prediabetes and obesity

Target Population: Adults

Objective: By December 31, 2021, decrease the percentage of adults ages 18 years and older with obesity by 2% (Albany County: from 25.0% in 2016 to 24.5% & Rensselaer County: from 30.4% to 28.4% by 2021).

Address Disparity: No

Intervention Strategies, Activities	Partner Resources	Partner Roles	Measures
Expand access to the National Diabetes Prevention Program (NDPP)	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Rensselaer County Department of Health** • Public health educator completed DPP lifestyle coach training • Promote evidence based self-management interventions for individuals with pre-diabetes **Albany Medical Center** • Promote evidence-based medical management in accordance with national guidelines **St. Peter's Health Partners** • SPHP Diabetes and Endocrine Care provides NDPP Classes throughout the Capital District.	**Albany County Department of Health** • Increase availability of NDPP. • Increase prediabetes awareness by community providers. • Promote prediabetes screening, testing, and referral. **Rensselaer County Department of Health** • Provide public health detailing to provider offices to promote local NDPP availability and on the CDC's pre-diabetes evidence based screening tool • Increase availability of NDPP. **Albany Medical Center** • Employs six full-time Certified Diabetes Educators for our patients with diabetes. • Promotes prediabetes screening, testing and referral. **Capital District YMCA, St. Peter's Health Partners Medical Associates; other certified providers:** Conduct NDPP classes. **St. Peter's Health Partners** • Increase availability of NDPP.	• Number of participants enrolled in NDPP. • To the extent possible, number and percentage of NDPP participants that complete program (i.e. attend at least 9 out of 16 core classes). • To the extent possible, measure NDPP participant outcomes (e.g. average weekly physical activity minutes, percent weight loss, Ha1c changes).

	• Serves on the Albany-Rensselaer Obesity Task Force, Albany County Strategic Alliance for Health and Rensselaer County Wellness Committee. **Healthy Capital District Initiative (HCDI):** Provides access to coverage and care, health-planning expertise, and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	• Conduct NDPP classes • Increase prediabetes awareness by SPHP providers. • Promote prediabetes screening, testing, and referral within SPHP and to CBOs **HCDI Obesity Task Force:** Promote NDPP, review and update *Capital District Diabetes Education and Support Services Guide*, review alternative lifestyle change programs.	
Expand access to evidence-based self-management interventions for individuals with chronic disease	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use the underlying risk factors for a variety of chronic diseases (including diabetes, obesity, and cardiovascular disease). **Rensselaer County Department of Health** **Albany Medical Center** • Promote evidence-based medical management in accordance with national guidelines **St. Peter's Health Partners** • SPHP Diabetes and Endocrine Care provides NDPP Classes & individual and group diabetes self-management programs • throughout the Capital District	**Albany County Department of Health** • Increase availability of NDPP. • Increase prediabetes awareness by community providers. • Promote prediabetes screening, testing, and referral. • Number of patients who participate in evidence-based self-management education programs (e.g. Blood Pressure Self-Monitoring, diabetes self-management) • **Rensselaer County Department of Health** **Albany Medical Center** • Albany Med providers work with patients with diabetes to develop a self-care plan to meet each individual's needs. **St. Peter's Health Partners** • Serves on the Albany-Rensselaer Obesity Task Force, Albany County Strategic Alliance for Health and Rensselaer County Wellness Committee • Increase availability of NDPP. • Number of patients who participate in evidence-based self-management education programs (e.g. Blood Pressure	• Number of participants in other (i.e. non-NDPP) chronic disease self-management programs that support Lifestyle Change (e.g. Blood Pressure Self-Monitoring, Diabetes Self-Management Support and Education aka DSMS/E). • To the extent possible, number of participants in other (i.e. non-NDPP) chronic disease self-management programs that improve health outcomes (e.g. change in blood pressure and/or blood glucose from uncontrolled to controlled to maintained; percent weight loss; changes in physical activity.

	Healthy Capital District Initiative (HCDI): Provides access to coverage and care, health-planning expertise, and supports health prevention programs across the Capital Region. Facilitates the Albany-Rensselaer Obesity Task Force.	Self-Monitoring, diabetes self-management • Promote prediabetes screening, testing, and referral **HCDI Obesity Task Force:** Promote alternative lifestyle change programs.	

Prevent Chronic Disease(s): Asthma in Albany & Rensselaer Counties

Goal 1 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma (with particular attention to communities with the high incidence of asthma in the City of Albany).

Target Population: Adults and Children

Objective(s): By December 31, 2021, decrease the asthma hospitalization rate per 10,000 for all age groups by 2% (Albany County: from 5.2/10,000 in 2016 to 5.1/10,000 & Troy/Lansingburgh (Rensselaer County) from: 22.8/10,000 in 2012-2016 to 22.3/10,000 by 2021).

By December 31, 2021, decrease the asthma emergency department visit rate per 10,000 for all age groups by 2% (Albany County: from 55.0/10,000 in 2016 to 53.9/10,000 and Troy/Lansingburgh (Rensselaer County) from: 109.8%/10,000 in 2016 to 107.6/10,000 by 2021).

Address Disparity: Yes (Geography, Race /ethnicity): particular attention to communities with the high incidence of asthma in the Cities of Albany & Troy/Lansingburgh.

Intervention Strategies, Activities	Partner Resources	Partner Roles	Measures
Expand access to home-based multi-trigger, multicomponent visits by licensed professionals or qualified lay health workers to provide targeted, intensive asthma self-management education and to reduce home asthma triggers for individuals whose asthma is not well-controlled with NAEPP Guidelines' medical management and asthma self-management education (ASME) inclusive of *Healthy Neighborhood Program* and asthma education services.	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use as the underlying risk factors for a variety of chronic diseases (including asthma). • *Healthy Neighborhoods Program* provides environmental hazard home assessments, education, and referrals to follow-up resources in high-risk communities. • Asthma educator(s) provide asthma self-management education and support. **Rensselaer County Department of Health** • *Healthy Neighborhoods Program* provides environmental hazard home assessments, education, and referrals to follow-up resources in high-risk communities • Asthma educator(s) provide asthma self-management education and support.	**Albany County Department of Health:** • Actively participate as a member of the Albany-Rensselaer Asthma/Tobacco Coalition. • For residents identified at risk for asthma, provide in-home asthma education services with community health worker supports. **Cornell Cooperative Extension** • Contracted to provide select *Healthy Neighborhood Program* activities. • Refers to asthma education services. **Rensselaer County Department of Health** • For residents identified at risk for asthma, provide in-home asthma education services with community health worker supports	• Number of *Healthy Neighborhood Program* home visits conducted. • Number of asthma educator home visits conducted. • To the extent possible, measure improvement(s) in patient asthma control test (ACT) scores.

	Albany Medical Center • Promote evidence-based medical management in accordance with national guidelines **St. Peter's Health Partners** • SPHP Home Based Asthma Management Program provides self-management education to individuals whose asthma is not well controlled **Healthy Capital District Initiative** • Facilitates the Albany-Rensselaer Asthma/Tobacco Coalition.	**Albany Medical Center** • Albany Med provides a wide range of services to prevent/educate and care for persons with asthma. Examples include region's only comprehensive asthma, allergy & immunology center (adult & peds), certified asthma educators, asthma research, host of annual CME Asthma, Allergy & Immunology conference, asthma care transition plans prescribed in our ED, various asthma-related initiatives through BHNNY. **St. Peter's Health Partners** • Actively participate as a member of the Albany-Rensselaer Asthma/Tobacco Coalition. • For patients whose asthma is not well controlled, provides in-home asthma education services with Respiratory Therapists and Community Health Workers. **Healthy Capital District Initiative** • Convenes Albany-Rensselaer Asthma/Tobacco Coalition meetings to engage regional stakeholders, share best practices/resources and support collaboration.	

Prevent Chronic Disease(s): Asthma in Albany & Rensselaer Counties

Goal 2 Promote tobacco use cessation (with particular attention to communities with the high incidence of asthma in the Cities of Albany & Troy).

Target Population: Adults and Children

Objective(s): By December 31, 2021, decrease the asthma hospitalization rate per 10,000 for all age groups by 2% (Albany County: from 5.2/10,000 in 2016 to 5.1/10,000 & Troy/Lansingburgh (Rensselaer County) from: 22.8/10,000 in 2012-2016 to 22.3/10,000 by 2021).

By December 31, 2021, decrease the asthma emergency department visit rate per 10,000 for all age groups by 2% (Albany County: from 55.0/10,000 in 2016 to 53.9/10,000 and Troy/Lansingburgh (Rensselaer County) from: 109.8%/10,000 in 2016 to 107.6/10,000 by 2021).

Address Disparity: Yes (Geography, Race /ethnicity): particular attention to communities with the high incidence of asthma in the Cities of Albany & Troy/Lansingburgh.

Intervention Strategies, Activities	Partner Resources	Partner Roles	Measures
Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment	**Albany County Department of Health** • Albany County Strategic Alliance for Health specifically targets poor nutrition, lack of physical activity, and tobacco use as the underlying risk factors for a variety of chronic diseases (including asthma). • Provides tobacco control service (i.e. enforcement of federal Clean Indoor Air Act, New York State Adolescent Tobacco Use Prevention Act, and Albany County prohibition on sale of tobacco products to persons under age 21). **Albany County Department of Mental Health –** per Local Services Plan for Mental Hygiene Services: • Conducts assessment of mental hygiene and associated issues; • Disseminates public health information regarding tobacco use and prevention; and • Provides and/or coordinates prevention, addiction treatment, and recovery support services. **Rensselaer County Department of Health**	**Albany County Department of Health** • Actively participate as a member of the Albany-Rensselaer Asthma/Tobacco Coalition. • Identify and publicize community tobacco cessation resources; • Assist development of referral processes to reduce tobacco use among severally mentally ill persons. **Albany County Department of Mental Health** • Capacity to provided tobacco cessation services; • Identify and publicize community tobacco cessation resources; • Develop referral processes to reduce tobacco use among severally mentally ill persons. **Rensselaer County Department of Health**	• Number of people screened for tobacco use • Number of people screened positive for tobacco use • Percentage of those who screened positive for tobacco use that have quit • Percentage of those who screened positive for tobacco use that reduced their use

	• Provides tobacco control service (i.e. enforcement of federal Clean Indoor Air Act, New York State Adolescent Tobacco Use Prevention Act, and NYS prohibition on sale of tobacco products to persons under age 21). • Disseminates public health information regarding tobacco use and prevention **Albany Medical Center** • Assist medical and behavioral health care organizations and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guideline, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. **St. Peter's Health Partners** • Provides resources and technical assistance for the implementation of the *Public Health Service Clinical Practice Guidelines* for tobacco dependence treatment within medical and behavioral health care organizations. • Promotes Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications. • Provides tobacco cessation services • Facilitates the Capital District Tobacco Free Communities • Disseminates public health information regarding tobacco use and prevention **Healthy Capital District Initiative** Facilitates the Albany-Rensselaer Asthma/Tobacco Coalition.	• Identify and publicize community tobacco cessation resources • Actively participates in the Albany-Rensselaer Asthma Tobacco Coalition • Public health educators will be trained to provide tobacco cessation classes and will offer classes in Troy Housing Authority communities to target low income residents **Albany Medical Center** • Albany Med advocates for smoke-free environments by providing tobacco cessation services for patients and their families, and links individuals who desire to quit with local community resources. **St. Peter's Health Partners** • Screens all patients for tobacco use and refers as appropriate to cessations services (NYS Smokers Quitline; SPHP. *The Butt Stops Here* and nicotine replacement therapy). • Provides *The Butt Stops Here* tobacco cessation program on site at multiple SPHP locations • Via the Capital District Tobacco Free Communities; uses media, health communications and *Reality Check* to highlight the dangers of tobacco and promote effective tobacco control policies • Actively participates as a member of the Albany-Rensselaer Asthma/Tobacco Coalition. **Healthy Capital District Initiative** • Convenes Albany-Rensselaer Asthma/Tobacco Coalition meetings to	

		engage regional stakeholders, share best practices/resources and support collaboration.	

Promote Well-Being and Prevent Mental and Substance Use Disorders in Albany & Rensselaer Counties

Goal 1: Facilitate supportive environments that promote respect and dignity for people of all ages

Target Population: Youth and Adults

Objective: By December 31, 2021 increase Community Score by 2% to 62.2 (baseline: 61.0 in 2018)

By December 31, 2021, reduce the age-adjusted suicide mortality rate by 10% in Rensselaer County from 12.5/100,000 to 11.5/100,000 by 2021

Address Disparity: No

Intervention, Strategies, Activities	Partner Resources	Partner Role	Measures
Implement *Mental Health First Aid*	**Albany County Department of Health** • Disseminates information regarding services for persons with mental illness. **Albany County Department of Mental Health –** per Local Services Plan for Mental Hygiene Services: • Conducts assessment of mental hygiene and associated issues; • Provides and coordinates a full range of services for persons with mental illness. • Provides and/or coordinates prevention, addiction treatment, and recovery support services. **Rensselaer County Department of Health** • Disseminates information regarding services for persons with mental illness. **Albany Medical Center** Continue efforts to expand access to behavioral health providers.	**Albany County Department of Health and Albany County Department of Mental Health** • Support and promote *Mental Health First Aid* trainings **Rensselaer County Department of Health** • Support and promote *Mental Health First Aid* & *Psychological First Aid* trainings • Relevant staff will be trained in Mental Health Firs Aid **Mental Health Association in New York State, Inc. (MHANYS)** • Provides *Mental Health First Aid* training **Albany Medical Center**: • Albany Med employs adult and pediatric behavioral health providers to provide mental health services and support to our patients.	• Number of persons completing in *Mental Health First Aid* training. • To the extent possible, measure change in knowledge among participants of a *Mental Health First Aid* Training before, after and 6 months after completing the training. • Number of families served by *Healthy Families* program.

	St. Peter's Health Partners • Provides and coordinates a full range of services for persons with behavioral health diagnosis's. • Provides and/or coordinates prevention, addiction treatment, and recovery support services. • Increase participation in the evidence based Home Visiting Programs among pregnant women and families, particularly those who are at risk.	• Aside from its department of Psychiatry, Albany Med currently integrates behavioral health care into a number of its primary care and specialty sites to improve access for our patients. **St. Peter's Health Partners** • Support and promote *Mental Health First Aid* trainings • Promote and provide referrals to *Healthy Families Program* (home visitation program for pregnant women and families) • Participate in internal and external workgroups, such as *Prescription for Progress* & *Project ECHO* in order to improve the mental health and well-being of community members • Operates Behavioral Health Service line in both Albany and Rensselaer Counties; providing a full range of services for persons with behavioral health diagnosis's	